SERFF Tracking Number:	*QUAC-127879907*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*50428*
Company Tracking Number:			
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*MediQ65*		
Project Name/Number:	*MediQ 65 2012 Application/*		

Filing at a Glance

Company: QualChoice Life and Health Insurance Company, Inc.

Product Name: MediQ65	SERFF Tr Num: QUAC-127879907	State: Arkansas
TOI: MS09 Medicare Supplement - Other 2010	SERFF Status: Closed-Approved-Closed	State Tr Num: 50428
Sub-TOI: MS09.000 Medicare Supplement Other 2010	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Jim Couch, Niki Thomas	Disposition Date: 12/14/2011
	Date Submitted: 12/08/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: MediQ 65 2012 Application	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments:
Explanation for Combination/Other:	Market Type:
Submission Type:	Overall Rate Impact:
Filing Status Changed: 12/14/2011	
State Status Changed: 12/14/2011	Deemer Date:
Created By: Niki Thomas	Submitted By: Niki Thomas
Corresponding Filing Tracking Number:	

Filing Description:

MediQ 65 2012 Application

Company and Contact

Filing Contact Information

Jim Couch, VP of Compliance	jim.couch@qualchoice.com
12615 Chenal Parkway, Suite 300	501-228-7111 [Phone] 5118 [Ext]
Little Rock, AR 72211	501-707-6729 [FAX]

SERFF Tracking Number:	*QUAC-127879907*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*50428*
Company Tracking Number:			
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*MediQ65*		
Project Name/Number:	*MediQ 65 2012 Application/*		

Filing Company Information

QualChoice Life and Health Insurance Company, Inc.	CoCode: 70998	State of Domicile: Arkansas
12615 Chenal Parkway, Suite 300	Group Code:	Company Type: Life & Health
Little Rock, AR 72211	Group Name:	State ID Number:
(501) 228-7111 ext. [Phone]	FEIN Number: 71-0386640	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 Form at $50.00 a form.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
QualChoice Life and Health Insurance Company, Inc.	$50.00	12/08/2011	54375977

SERFF Tracking Number:	*QUAC-127879907*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*50428*
Company Tracking Number:			
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*MediQ65*		
Project Name/Number:	*MediQ 65 2012 Application/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	12/14/2011	12/14/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
2012 MediQ65 Application	Note To Reviewer	Niki Thomas	12/08/2011	12/08/2011

SERFF Tracking Number:	*QUAC-127879907*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*50428*
Company Tracking Number:			
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*MediQ65*		
Project Name/Number:	*MediQ 65 2012 Application/*		

Disposition

Disposition Date: 12/14/2011
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*QUAC-127879907*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*50428*
Company Tracking Number:			
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*MediQ65*		
Project Name/Number:	*MediQ 65 2012 Application/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	2012 Application	Approved-Closed	Yes

SERFF Tracking Number:	*QUAC-127879907*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*50428*
Company Tracking Number:			
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*MediQ65*		
Project Name/Number:	*MediQ 65 2012 Application/*		

Note To Reviewer

Created By:
Niki Thomas on 12/08/2011 02:33 PM
Last Edited By:
Stephanie Fowler
Submitted On:
12/14/2011 12:37 PM
Subject:
2012 MediQ65 Application
Comments:
VIA SERFF

December 8, 2011

Ms. Stephanie Fowler
Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: QualChoice Life and Health Insurance Company, Inc. Medicare Supplement Policy Application Filing

Dear Ms. Fowler:

Attached please find QualChoice Life and Health Insurance Company, Inc.'s filing for its Medicare Supplement Policy 2012 Applications. I am also attaching directly to this Note to Reviewer a pdf copy highlighting the changes made from the previously approved application. All changes have been noted in blue.

Please feel free to contact me at any time should you need additional information or have any questions or comments. Thank you.

Sincerely,

SERFF Tracking Number:	*QUAC-127879907*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*50428*
Company Tracking Number:			
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*MediQ65*		
Project Name/Number:	*MediQ 65 2012 Application/*		

J. Nicole Thomas, J.D.
Associate Corporate Counsel
Nicole.Thomas@qualchoice.com
(501) 219-5129

MediQ65®

APPLICATION FOR COVERAGE

MediQ65® Medicare Supplement Insurance

Thank you for selecting QualChoice MediQ65® for your Medicare Supplement insurance coverage. You must be age 65, a resident of the State of Arkansas, and have both Medicare Part A and Medicare Part B to apply for these plans.

Please read the following information carefully to assure prompt processing of your application. A MediQ65® Application Packet is also available at **www.mediq65.com.**

1. This application is a legal document. If you are approved for coverage, it will become part of your contract. Therefore, it is very important that you provide all requested information and that it is accurate and legible.
2. You must be 65 years of age and reside in Arkansas to apply for a MediQ65® Medicare Supplement plan.
3. This form can be completed by an agent/broker authorized to sell QualChoice MediQ65® policies, or you can fill it in yourself.
4. Answer each required question completely using dark blue or black ink. No pencil please.
5. Do not use liquid paper, correction tape or "white out" to correct any mistakes.
6. If you make a mistake, mark through the incorrect information, initial it and then provide the correct information.
7. All required sections must be completed to avoid delays in processing.
8. Any attached sheets must be **signed** and **dated**.
9. Be sure to make a photocopy of this completed application and any attachments for your records.
10. The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be viewed at **www.mediq65.com**.
11. You must **sign** and **date** the application.
12. In order to use Monthly Bank Draft as your payment method, a voided blank check must be submitted with the application. If electing Monthly billing as your payment option, DO NOT send money with this application. You will be billed later.
13. **Return this entire application and any attachments in the postage-paid return envelope provided.** If certain sections do not apply to you, indicate so on application.

Policy Effective Dates

The policy effective date will be the 1st of the month after your completed application is approved and processed.

Rules For Effective Dates:

- You cannot have an effective date prior to your Medicare Part A and Part B effective dates.
- You cannot have an effective date prior to your termination from a Medicare Advantage plan.
- You cannot have an effective date prior to your application submission date.

Questions or Need Assistance?

1.855.MEDIQ65 (1.855.633.4765)

Monday – Friday 8 a.m. to 5 p.m.

SECTION VI. ELIGIBILITY INFORMATION (cont'd.)

Please check (✓) either **YES** or **NO**.

5. If you had coverage from any Medicare plan, other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO, PPO or PFFS), fill in your START DATE and END DATE below. If you are still covered under this plan, leave the **END DATE** blank.

START DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)

a. If you are still covered under the other Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	☐ YES ☐ NO
b. Was this your first time in this type of Medicare plan?	☐ YES ☐ NO
c. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ YES ☐ NO
6. Do you have another Medicare supplement policy in force?	☐ YES ☐ NO

a. If **YES**, what is the name of the company? And what plan do you have?

NAME OF COMPANY	NAME OF PLAN

b. If **YES**, do you plan to replace your current Medicare supplement policy with this MediQ65® policy?	☐ YES ☐ NO
7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?)	☐ YES ☐ NO
a. If **YES**, please list name of carrier.	

b. If **YES**, What are your dates of coverage under the other policy? If you are still covered under the other policy, leave the **END DATE** blank.

START DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)

Important Information!

Please read carefully before continuing the application process.

Open Enrollment Period

Under the OPEN ENROLLMENT PERIOD health questions are **not** required to be answered. You are **NOT** required to complete **Sections VII-IX** if you are applying during the Medicare Supplement Open Enrollment Period. Please continue your application process at **Section X.**

If You Are NOT in the Open Enrollment Period

Please answer **ALL** of the following health questions. Acceptance or rejection of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage and our review of your answers to the medical questions. Your application cannot be processed unless all questions are answered.

Underwritten by QualChoice Life and Health Insurance Company, Inc.
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SECTION XI: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FORM

Your application cannot be processed without this form being signed and returned.

1. I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, prior insurance carrier, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, any third party retained by QualChoice, or its reinsurers, information with respect to any physical or mental condition, treatment or any non-medical information on me.
2. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage.
3. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits.
4. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice *Notice of Privacy Practices*.
5. I understand that information provided under this authorization if re-disclosed will no longer be protected. However, QualChoice and its associates are protected by federal and state privacy laws and regulations.
6. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me to my broker/agent.
7. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501.
8. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice.
9. I understand that I may terminate this authorization by sending a written revocation to QualChoice, **ATTN: MEDIQ65®, P.O. Box 25626, Little Rock, AR 72221-5626**. However, if I revoke this authorization before I am enrolled in the MediQ65 policy, my application for coverage will be denied.
10. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims.
11. A photocopy of this authorization is as valid as the original.
12. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i)
13. QualChoice may release any information obtained by it about me to MIB or any member company for purposes described in QualChoice's *Notice of Privacy Practices*.

This authorization must be signed by each proposed insured who is 18 years of age or older.

PRINTED NAME OF APPLICANT

SIGNATURE OF APPLICANT

X

DATE SIGNED (MM/DD/YYYY)

SERFF Tracking Number:	*QUAC-127879907*	*State:*	*Arkansas*
Filing Company:	*QualChoice Life and Health Insurance Company, Inc.*	*State Tracking Number:*	*50428*
Company Tracking Number:			
TOI:	*MS09 Medicare Supplement - Other 2010*	*Sub-TOI:*	*MS09.000 Medicare Supplement Other 2010*
Product Name:	*MediQ65*		
Project Name/Number:	*MediQ 65 2012 Application/*		

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/14/2011	110+MK+007_01 MQAPP_01	Application/ Enrollment Form	2012 Application	Initial			MediQ65 Application Packet_12.11.pdf

Medicare Supplement Insurance

MediQ65®

APPLICATION PACKET

- Open Enrollment Period
- Application for Coverage
- Important Information for Applicant Form
- Authorization to Disclose Protected Health Information (PHI) Form
- Payment Authorization Form
- Fair Credit Reporting Act Notice

Quick Checklist

Complete, sign and return the following forms in the enclosed postage-paid return envelope.

☐	*Application for Coverage*
☐	*Important Information for Applicant Form*
☐	*Authorization to Disclose PHI Form*
☐	*Payment Authorization Form* (Attach check marked *VOID* if selecting *Monthly Bank Draft*.)

QualChoice®

IMPORTANT INFORMATION!

Please read carefully before beginning the application process.

Do You Qualify for a Medigap Policy?

You may apply for a Medicare Supplement policy at any time. However, there is an important enrollment period to take advantage of called the Medigap **Open Enrollment Period** (OEP).

- State and federal laws guarantee that for a period of six months from the date you become enrolled in Medicare Part B and you are age 65 or older you have a right to buy a Medicare supplement policy of your choice, regardless of medical history, health status, or prior claims.
- The six-month period begins the first day of the month you are enrolled in Medicare Part B **and** are age 65 or older.
- If your birthday falls on the first day of the month, your Medicare coverage will begin the first day of the previous month, while you are age 64. Your Open Enrollment Period will also begin at that time.

Medicare Part B Coverage Deferred

If you are age 65 or older and have deferred your Medicare Part B coverage, your Open Enrollment Period begins with the date your Medicare Part B coverage becomes effective and continues for six months.

Medicare Disabled

Federal law does not require that people under the age of 65 with Medicare Part B as a result of disability or permanent kidney failure be given an Open Enrollment Period. However, when you turn 65, you will have an Open Enrollment Period opportunity. Your Open Enrollment Period begins with the first day of the month in which you turn age 65 and continues for six months.

FOR MORE INFORMATION ABOUT MEDICARE AND MEDIGAP
MediQ65 Medicare Supplement Plan — Weekdays 8 a.m. to 5 p.m. Central Time
Toll Free **1.855.MEDIQ65 (1.855.633.4765)** **www.mediq65.com**
Senior Health Insurance Information Program (SHIIP – State of Arkansas) provides free one-on-one counseling, education, and information to individuals with Medicare of all ages.
Toll Free **1.800.224.6330** or **501.371.2782** **www.insurance.arkansas.gov**
Medicare — 24 hours a day, 7 days a week
Toll Free **1.800.633.4227 (1.800.MEDICARE) • TTY/TDD users call 1.877.486.2048** ***Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*** available at **www.medicare.gov/publications**

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MediQ65®

APPLICATION FOR COVERAGE

MediQ65® Medicare Supplement Insurance

Thank you for selecting QualChoice MediQ65® for your Medicare Supplement insurance coverage. You must be age 65, a resident of the State of Arkansas, and have both Medicare Part A and Medicare Part B to apply for these plans.

Please read the following information carefully to assure prompt processing of your application. A MediQ65® Application Packet is also available at **www.mediq65.com.**

1. This application is a legal document. If you are approved for coverage, it will become part of your contract. Therefore, it is very important that you provide all requested information and that it is accurate and legible.
2. You must be 65 years of age and reside in Arkansas to apply for a MediQ65® Medicare Supplement plan.
3. This form can be completed by an agent/broker authorized to sell QualChoice MediQ65® policies, or you can fill it in yourself.
4. Answer each required question completely using dark blue or black ink. No pencil please.
5. Do not use liquid paper, correction tape or "white out" to correct any mistakes.
6. If you make a mistake, mark through the incorrect information, initial it and then provide the correct information.
7. All required sections must be completed to avoid delays in processing.
8. Any attached sheets must be **signed** and **dated**.
9. Be sure to make a photocopy of this completed application and any attachments for your records.
10. The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be viewed at **www.mediq65.com**.
11. You must **sign** and **date** the application.
12. In order to use Monthly Bank Draft as your payment method, a voided blank check must be submitted with the application. If electing Monthly billing as your payment option, DO NOT send money with this application. You will be billed later.
13. **Return this entire application and any attachments in the postage-paid return envelope provided.** If certain sections do not apply to you, indicate so on application.

Policy Effective Dates

The policy effective date will be the 1st of the month after your completed application is approved and processed.

Rules For Effective Dates:

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- You cannot have an effective date prior to your termination from a Medicare Advantage plan.
- You cannot have an effective date prior to your application submission date.

Questions or Need Assistance?

1.855.MEDIQ65 (1.855.633.4765)

Monday – Friday 8 a.m. to 5 p.m.

SECTION I. WHO IS APPLYING

FIRST NAME	MI	LAST NAME

SOCIAL SECURITY NUMBER	DATE OF BIRTH (MM/DD/YYYY)	AGE	GENDER	COUNTY OF RESIDENCE
☐☐☐ ☐☐ ☐☐☐☐	☐☐ ☐☐ ☐☐☐☐		☐ Male ☐ Female	

PRIMARY PHONE NUMBER	SECONDARY PHONE NUMBER	BEST TIME TO CALL
		AM PM

MAILING ADDRESS (No PO Box, please)	CITY	STATE	ZIP CODE
		AR	

BILLING ADDRESS (Complete only if different from residential address)	CITY	STATE	ZIP CODE
		AR	

RESIDENTIAL ADDRESS (Complete only if different from residential address)	CITY	STATE	ZIP CODE
		AR	

EMAIL ADDRESS Please check *(✓)* one. **Yes** ☐ **No** ☐

IMPORTANT DECISION: *I want to do my part for the environment and reduce waste.* ***By checking YES, I agree that QualChoice can deliver all documents, notices and any other communications with respect to my MediQ65® coverage electronically to my email address below****. This includes, but is not limited to, my Insurance* ***Certificate of Coverage****, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications.* ***I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting QualChoice at 1.855.MEDIQ65 (1.855.633.4765).*** *I also understand that I can ask QualChoice at any time to provide me with any of these documents in paper form by regular mail. I agree to contact QualChoice if my email address changes so that these important documents, notices and communications will come to my new email address.*

PLEASE PRINT YOUR EMAIL ADDRESS BELOW

SECTION II. BILLING PREFERENCE Check *(✓)* only one.

Please check your preferred billing option **and** complete **Section XII: PAYMENT AUTHORIZATION FORM**
If billing option is left blank, your policy will automatically default to Monthly Invoice Billing (a $2.00 monthly service fee will apply).

☐ Monthly Bank Draft ☐ Monthly Billing ($2.00 monthly service fee) ☐ Quarterly Billing

SECTION III. CHOOSE YOUR PLAN

Check (✓) only one. Please enroll me in the following MediQ65® Plan.	☐ MediQ65® **Plan A**	☐ MediQ65® **Plan F**	☐ MediQ65® **Plan G**	☐ MediQ65® **Plan N**

Do you currently have QualChoice health coverage?	☐ **No** ☐ **Yes**	If **YES**, please write your QualChoice ID No. below.

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SECTION IV. EFFECTIVE DATE

Your effective date will be the *1st of the month* after your completed application is approved and processed. Effective date of coverage cannot be prior to your Medicare Part B effective date.

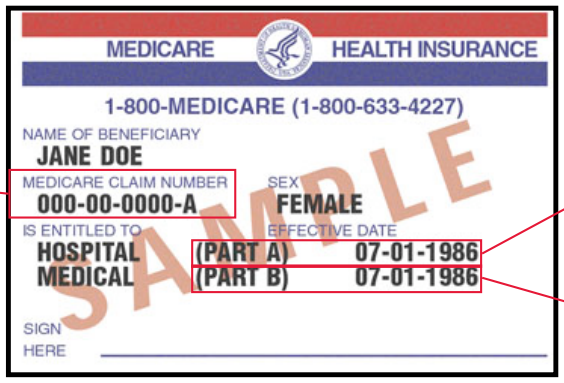
SECTION V. YOUR MEDICARE INSURANCE INFORMATION

You must have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for MediQ65®

Please FILL IN THE BLANKS below to match your red, white and blue Medicare Health Insurance card.

1. MEDICARE CLAIM NUMBER	2. HOSPITAL (**Part A**) EFFECTIVE DATE (MM/DD/YYYY)	3. MEDICAL (**Part B**) EFFECTIVE DATE (MM/DD/YYYY)
☐☐☐ - ☐☐ - ☐☐☐☐	☐☐ ☐☐ ☐☐☐☐	☐☐ ☐☐ ☐☐☐☐

1. MEDICARE CLAIM #



2. HOSPITAL (**Part A**)

3. MEDICAL (**Part B**)

SECTION VI. ELIGIBILITY INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. ***Please include a copy of the notice from your prior insurer with this application.***	Please check (✓) either **YES** or **NO.**
1. Did you turn age 65 in the last 6 months?	☐ YES ☐ NO
2. Did you enroll in Medicare Part B in the last 6 months?	☐ YES ☐ NO
a. If **YES**, what is the effective date? (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐	
3. Are you covered for medical assistance through the state Medicaid program? **NOTE TO APPLICANT:** If you are participating in a *Spend-Down Program* and have not met your *Share of Cost,* please respond **NO** to this question	☐ YES ☐ NO
a. If **YES**, will Medicaid pay your premiums for this Medicare supplement policy?	☐ YES ☐ NO
4. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?	☐ YES ☐ NO

(Continued on next page)

SECTION VI. ELIGIBILITY INFORMATION (cont'd.)

Please check (✓) either **YES** or **NO**.

5. If you had coverage from any Medicare plan, other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO, PPO or PFFS), fill in your START DATE and END DATE below. If you are still covered under this plan, leave the **END DATE** blank.

START DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)

a. If you are still covered under the other Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	☐ YES ☐ NO
b. Was this your first time in this type of Medicare plan?	☐ YES ☐ NO
c. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ YES ☐ NO
6. Do you have another Medicare supplement policy in force?	☐ YES ☐ NO

a. If **YES**, what is the name of the company? And what plan do you have?

NAME OF COMPANY	NAME OF PLAN

b. If **YES**, do you plan to replace your current Medicare supplement policy with this MediQ65® policy?	☐ YES ☐ NO
7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?)	☐ YES ☐ NO
a. If **YES**, please list name of carrier.	

b. If **YES**, What are your dates of coverage under the other policy? If you are still covered under the other policy, leave the **END DATE** blank.

START DATE (MM/DD/YYYY)	END DATE (MM/DD/YYYY)

Important Information!

Please read carefully before continuing the application process.

Open Enrollment Period

Under the OPEN ENROLLMENT PERIOD health questions are **not** required to be answered. You are **NOT** required to complete **Sections VII-IX** if you are applying during the Medicare Supplement Open Enrollment Period. Please continue your application process at **Section X.**

If You Are NOT in the Open Enrollment Period

Please answer **ALL** of the following health questions. Acceptance or rejection of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage and our review of your answers to the medical questions. Your application cannot be processed unless all questions are answered.

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SECTION VII. MEDICAL QUESTIONS (If this section applies to you, please answer all questions.)

Please check (✓) either **YES** or **NO**.

1. What is your height? ☐ ft. ☐☐ in.	What is your weight? ☐☐☐ lbs.
2. Are you Medicare disabled?	☐ YES ☐ NO
If **YES**, please indicate disability conditions below.	
3. Do you have a pacemaker?	☐ YES ☐ NO
4. Are you now a patient in a hospital or nursing home?	☐ YES ☐ NO
5. Have you ever been declined or rated for the issuance of life, accident or health or long term care insurance?	☐ YES ☐ NO
If **YES**, please explain	
6. Have you used any form of tobacco within the past 12 months?	☐ YES ☐ NO
If **YES**, please indicate type of tobacco and amount below:	

TYPE OF TOBACCO	AMOUNT OF USE

(Continued on next page)

SECTION VII. MEDICAL QUESTIONS (cont'd.)

Please check (✓) either **YES** or **NO**.

Have you ever had any diagnosis of or been advised to have treatment for any of the following?
If you respond YES, please complete Section VIII.

7. Disease or disorder of the heart or circulatory system, or high blood pressure or stroke?	☐ YES ☐ NO
8. Disease or disorder of the lungs or respiratory system?	☐ YES ☐ NO
9. Disease or disorder of the kidneys, liver, gallbladder, intestines, rectum, stomach, or other vital organs?	☐ YES ☐ NO
10. Diabetes or high blood sugar?	☐ YES ☐ NO
If **YES**, provide date of onset: (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐	
11. Mental incapacitation, Alzheimer's disease, mental disease, depression or psychiatric treatment?	☐ YES ☐ NO
12. Physical incapacitation, epilepsy, Parkinson's disease or disorder of the nervous system?	☐ YES ☐ NO
13. Cancer or malignancy?	☐ YES ☐ NO
14. Disease or disorder of the blood, glands, or skin?	☐ YES ☐ NO
15. Arthritis, paralysis, disease or disorder of the muscles, bones or joints?	☐ YES ☐ NO
16. Have you consulted a physician or received hospital (inpatient or outpatient care) or rehabilitation services during the past five years?	☐ YES ☐ NO
17. Have you ever had or been advised to have treatment for any condition not listed above?	☐ YES ☐ NO
18. In the past 3 years have you taken any medications prescribed by a health care provider?	☐ YES ☐ NO
If **YES**, list medications in **Section IX**.	

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SECTION VIII. ADDITIONAL MEDICAL INFORMATION

If you answered **YES** to any question in **Section VII**, complete this section. Attach additional sheets, if necessary. **Attachments must be signed and dated.**

*Type of Treatment includes, but is not limited to: surgery, hospitalization, doctor visit, emergency room, chiropractic treatments, rehabilitation therapy (speech, physical, occupational), nursing home.

QUESTION NUMBER (Sect. VII)	CONDITION/ ILLNESS	TYPE OF TREATMENT*	DATE (MM/YYYY)		DEGREE OF RECOVERY			COMPLETE NAME & ADDRESS OF PHYSICIAN
			First Visit	Last Visit	None	Partial	Full	

SECTION IX. PRESCRIPTION DRUGS

Complete this section if you responded **YES** to **Question 18 (Section VII: Medical Questions)**

NAME OF MEDICATION (from your pharmacy label)	PRESCRIBING PHYSICIAN	DOSAGE	DATES TAKEN (MM/YYYY)	
			Start Date	Stop Date

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SECTION X: IMPORTANT INFORMATION FOR APPLICANT FORM. ***Please read carefully and sign.***

Your application cannot be processed without this form being signed and returned.

Send no money with this application. You will be billed.

1. You do not need more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. If, after purchasing this policy you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

IN SIGNING BELOW, I REPRESENT AND ACKNOWLEDGE

1. That I should not cancel any coverage I currently have until I am notified of QualChoice's decision.
2. An agent/broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the agent /broker.
3. If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information.
4. I agree any provider of medical services or supplies is authorized and directed to furnish QualChoice all records or copies thereof, relating to such services or supplies.
5. I authorize and release to QualChoice, Title XVIII Medicare claims information needed to coordinate benefits with this policy at any time I am eligible for Medicare benefits
6. QualChoice may phone me for additional information that may help with the timely processing of my application.

(Continued on next page)

7. That the statements and answers given in this application and any signed and dated addenda to this application (both front and back) are true, complete and correctly recorded.

8. I have read and understand the ***Important Information for Applicant*** (Section X).

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I, the applicant, certify that I signed this application in the state of Arkansas.

☐ I, the applicant or my authorized representative, acknowledge receipt of the following:

(1) ***Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*** (available at www.medicare.gov/publications)

(2) ***Outline of Medicare Supplement Coverage*** from QualChoice

SIGNATURE OF APPLICANT	DATE SIGNED (MM/DD/YYYY)
X	☐☐ ☐☐ ☐☐☐☐

FOR AGENT / BROKER ONLY

If application is being made through an agent/broker, he/she must complete the following information.

I have read and understand the MediQ65® Application for Coverage. I additionally certify that the applicant has received the ***Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*** *and the* ***Outline of Medicare Supplement Coverage*** *for the policy applied for and that the applicant has Medicare Parts A and B. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage.*

Before this form can be processed, the agent/broker's current health and life license must be on file with QualChoice. In addition, the agent/broker must be appointed with QualChoice.

AGENCY FEDERAL TAX ID # (IF APPLICABLE)	AGENT/BROKER LICENSE #	PHONE NUMBER
AGENT/BROKER PRINTED NAME	**AGENT/BROKER SIGNATURE**	**DATE SIGNED (MM/DD/YYYY)**
	X	☐☐ ☐☐ ☐☐☐☐

List below all health insurance policies you have issued to this applicant that are still in force and any other health insurance issued in the past five (5) years that are no longer in force and submit with this application as required.

NAME OF POLICY	NAME OF INSURANCE COMPANY	POLICY DATE (MM/DD/YYYY)	
		To	From

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SECTION XI: AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION (PHI) FORM

Your application cannot be processed without this form being signed and returned.

1. I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, prior insurance carrier, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, any third party retained by QualChoice, or its reinsurers, information with respect to any physical or mental condition, treatment or any non-medical information on me.
2. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage.
3. This information shall also be used by QualChoice in investigating and adjudicating claims for benefits.
4. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice *Notice of Privacy Practices*.
5. I understand that information provided under this authorization if re-disclosed will no longer be protected. However, QualChoice and its associates are protected by federal and state privacy laws and regulations.
6. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me to my broker/agent.
7. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501.
8. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice.
9. I understand that I may terminate this authorization by sending a written revocation to QualChoice, **ATTN: MEDIQ65®, P.O. Box 25626, Little Rock, AR 72221-5626**. However, if I revoke this authorization before I am enrolled in the MediQ65 policy, my application for coverage will be denied.
10. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims.
11. A photocopy of this authorization is as valid as the original.
12. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i)
13. QualChoice may release any information obtained by it about me to MIB or any member company for purposes described in QualChoice's *Notice of Privacy Practices*.

This authorization must be signed by each proposed insured who is 18 years of age or older.

PRINTED NAME OF APPLICANT

SIGNATURE OF APPLICANT

X

DATE SIGNED (MM/DD/YYYY)

Section XII. PAYMENT AUTHORIZATION FORM

Use this form to select the type of payment method you want QualChoice to apply when billing your MediQ65® premium. Your application cannot be processed without this form being signed and returned.

Check (✓) one of the payment methods below.

☐ **Bank Draft (Monthly).** I authorize QualChoice and the Bank/Financial Institution indicated below, to debit my MediQ65® premium from the account indicated below. This authority is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement. I understand that by revoking the Bank Draft after I have agreed to it, I will also be terminating my MediQ65® coverage, UNLESS QualChoice has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the Bank Draft withdrawal date. I understand that if my bank rejects a draft due to insufficient funds in my account, QualChoice may charge me a fee of up to $20.00. In order to use Monthly Bank Draft as my payment method, I understand that I must submit this form to QualChoice and staple a blank check marked VOID in the top left-hand corner of this form. My first month's premium will be drafted upon initial acceptance of coverage. For all other premiums I may select one of two bank draft dates.

I understand and agree that my first month's premium will be drafted upon initial acceptance of coverage.

PLEASE CHECK ONE: For all other bank drafts I select the following date. ***Example****: Premiums due in January coverage month can be drafted on the 24th of December or the 5th of January.*

☐ 24th of the month preceding the coverage month

☐ 5th of the coverage month

NAME OF BANK OR FINANCIAL INSTITUTION	ACCOUNT TYPE (CHECK ONE) ☐ CHECKING ☐ SAVINGS
BANK ACCOUNT NUMBER	9 DIGIT BANK ROUTING NO.
ACCOUNT HOLDER NAME	ACCOUNT HOLDER ADDRESS (Street, City, State, Zip)
ACCOUNT HOLDER SIGNATURE **X**	DATE SIGNED (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

☐ **Monthly Billing ($2.00 monthly service fee applies).** Your monthly invoice will be mailed to your Billing Address as listed in Section I.

☐ **Quarterly Billing.**
I authorize QualChoice to bill my MediQ65® premium on a quarterly basis. This type of billing arrangement is to remain in full force and effect until QualChoice receives written notice of my desire to change my billing arrangement. I must provide QualChoice notice to change my billing arrangement twenty (20) days prior to when my next premium payment is due. In order to use quarterly billing as my payment method, I understand that I must submit this form to QualChoice.

By signing this PAYMENT AUTHORIZATION FORM, I agree to all terms and conditions expressed in the payment method I have chosen above. I understand that not properly following what has been authorized on this form may cause my MediQ65® policy to be terminated at QualChoice's discretion.

PRINTED NAME OF APPLICANT	
SIGNATURE OF APPLICANT **X**	DATE SIGNED (MM/DD/YYYY) ☐☐ ☐☐ ☐☐☐☐

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FAIR CREDIT REPORTING ACT NOTICE

Notice to Proposed Insured

Please keep for your records.

In connection with your application for insurance an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to:

QualChoice MediQ65®
Underwriting Division
PO Box 25626
Little Rock, AR 72221-5626

MediQ65®

DISCLAIMER

MediQ65 Medicare Supplement plans are not connected with or endorsed by the U.S. government or the federal Medicare program.

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Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Application Flesch Certification.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: The application is also the form filing.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Health - Actuarial Justification
Bypass Reason: The actuarial justification for each Medicare Supplement Policy has already been submitted and approved.
Comments:

Item Status: **Status Date:**

Bypassed - Item: Outline of Coverage
Bypass Reason: The Outline of Coverage for the applicable Plans was previously submitted and approved.
Comments:

QualChoice®

VIA SERFF

December 8, 2011

Ms. Stephanie Fowler
Arkansas Department of Insurance
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE: QualChoice Life and Health Insurance Company, Inc. Medicare Supplement Application Filing

Dear Ms. Fowler:

This certifies that the attached filing does not meet the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. §23-80-206:

Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. §23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

Please feel free to contact me at any time should you need additional information or have any questions or comments.

Sincerely yours,

J. Nicole Thomas, J.D.
Associate corporate Counsel

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